

## **APPENDIX B**

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### **OUTCOME AND ASSESSMENT INFORMATION SET OASIS-B1 (12/2002)**

Appendix B contains the eight sections listed below. Each section has a cover page that explains the purpose of the document.

1. Medicare's OASIS: Standardized Outcome and Assessment Information Set for Home Health Care
2. Copyright Release (permission to copy and reprint OASIS) from the Center for Health Services Research
3. Outcome and Assessment Information Set OASIS-B1 (12/2002)
4. Comparison Between SOC/ROC, Follow-Up, Discharge, and Inpatient Transfer Versions of OASIS-B1 (12/2002)
5. Start of Care Version of the Outcome and Assessment Information Set OASIS-B1 SOC (12/2002) – (also used for Resumption of Care Following Inpatient Stay)
6. Follow-Up Version of the Outcome and Assessment Information Set OASIS-B1 FU (12/2002)
7. Transfer Version of the Outcome and Assessment Information Set OASIS-B1 TRANSFER (12/2002) – (used for Transfer to an Inpatient Facility)
8. Discharge Version of the Outcome and Assessment Information Set OASIS-B1 DC (12/2002) – (also used for Transfer to an Inpatient Facility or Patient Death at Home)

These forms are available for viewing, downloading, or printing from CMS' OASIS Web site at

<a href="http://www.cms.hhs.gov/oasis/oasisdat.asp">http://www.cms.hhs.gov/oasis/oasisdat.asp</a>
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**Medicare's OASIS:  
Standardized Outcome and Assessment Information Set  
for Home Health Care**

Explanatory prologue for the Outcome and Assessment Information Set (OASIS). This document, published in a special supplement to *NAHC Report*, No. 625, August 11, 1995, provides historical information on the purpose of OASIS, its development, and the use of the OASIS in the context of outcome-based quality improvement. Some of the details have changed with subsequent Federal Regulations.



## **MEDICARE'S OASIS: STANDARDIZED OUTCOME AND ASSESSMENT INFORMATION SET FOR HOME HEALTH CARE – July 1999**

Peter W. Shaughnessy, Ph.D.  
Kathryn S. Crisler, M.S., R.N.  
Robert E. Schlenker, Ph.D.  
David F. Hittle, Ph.D.  
University of Colorado

The Outcome and Assessment Information Set (OASIS) that HCFA is requiring for purposes of outcome-based quality improvement under Medicare (as part of the new Conditions of Participation) has undergone several years of development and refinement. In addition to reviewing the purpose and evolution of the OASIS to date, this prologue provides information on selected operational issues.

### **Purpose, History, and Improvements**

The data items that constitute the OASIS were developed largely for purposes of measuring patient outcomes in home health care. Nearly all of the items also are useful for assessing the care needs of patients, but no pretense is made that the OASIS constitutes a comprehensive assessment instrument. Since the vast majority of OASIS items are similar to those currently used by most home health agencies at start of care (often in less precise form), it is intended that home care agencies and others replace their current versions of these items with the actual OASIS items. Experience in various demonstration programs has shown that this enables home care providers to conduct more precise assessments of patient conditions for these items.

The OASIS has its genesis in 12 years of research, development, and demonstration programs to design and test outcome measures for home care (funded by HCFA and The Robert Wood Johnson Foundation). One of the important products from this program was a 73-item data set required to measure outcomes, first published in a 1994 report written by the Center for Health Services and Policy Research (the Research Center) at the University of Colorado. This was expanded to a 79-item data set as a result of recommendations from a HCFA-convened task force of home care experts who reviewed the data set from the perspective of items judged essential for assessment. The Research Center revised and rearranged the 79 items into a data set format termed OASIS-A in 1995.

The OASIS-A items that had been developed and tested in the national research program (along with those added by the expert panel) were then used operationally in two demonstration programs (summarized below) beginning in late 1995 and 1996. This experience suggested selected refinements, resulting in OASIS-B, which contained 79 items. Although a few items were dropped, a few were added, and wording changes were made to clarify items, the substance of OASIS-B was virtually the same as OASIS-A. The current (1998) release of OASIS, termed OASIS-B1, includes modifications to the patient identifiers (termed clinical record items) and one demographic item. These modifications are intended to assist HCFA in tracking and managing data. As the Medicare program moves forward with OASIS, it is clear such identifiers (also used for billing, care planning, etc., under Medicare) would naturally accompany the core OASIS items and be of value for agency-specific applications of OASIS.

Thus, OASIS-B was largely the result of applying and testing OASIS-A, beginning in 1996 in (1) the national demonstration of outcome-based quality improvement (OBQI) that HCFA is sponsoring and the University of Colorado Research Center is administering, and (2) an

analogous OBQI demonstration in New York State that the Department of Health is sponsoring and the University of Colorado Research Center is administering. The experience of the 50 national demonstration agencies and the 22 New York State demonstration agencies in using the OASIS for purposes of collecting outcome data, as well as selected experiences of other agencies throughout the country which have elected to use the OASIS data set, were taken into consideration in the modest set of revisions that initially resulted in OASIS-B.

Further experience in the demonstrations and in HCFA's needs for data management and administration subsequently were taken into consideration in refining OASIS-B to produce OASIS-B1. Reliability testing, programmatic applications, and provider suggestions to improve OASIS will continue with a view toward improving the data set. Nonetheless, OASIS is now regarded as a stable data set that can be used in the context of patient assessment and outcome monitoring. At the same time as home care practices, patient conditions, and policies change, it will be necessary to occasionally update and refine the data set. As other revisions are released, the suffixes "C," "D," etc. will be used.

One of the primary reasons OASIS has been deemed stable and useful for the home care field is its multiplicity of successful applications in the demonstration programs. Nearly all demonstration agencies have been extremely successful in effectively and precisely implementing and maintaining OASIS data collection. This in turn has resulted in accurate and useful outcome reports, case mix reports, and adverse event reports. Using the findings from the outcome reports and developing methods to evaluate the care that influences specific outcomes, a majority of agencies in the national demonstration changed care behaviors to produce improved outcomes in the areas they targeted for improvement.

It is our intent at the Research Center to provide the home care industry with regular updates on OBQI demonstrations, operational issues related to OBQI that are important to both individual agencies and Medicare, strengths and weaknesses associated with using the OASIS for various purposes, and other issues pertinent to smoothly and effectively implementing the OASIS data set in order to measure outcomes. We have used and will continue to use several different forums for these communications (including the HCFA website, since much of our home care research is sponsored by HCFA). Information related to operational features of the OASIS is summarized in subsequent paragraphs.

### **Operational Issues**

With respect to understanding and using OASIS data items, several points are important to take into consideration. Since the OASIS is used for measuring outcomes defined as change in health status between two or more time points, most data items are obtained at start of care and follow-up time points (i.e., every two calendar months and discharge). Selected items are unique to either start of care or follow-up times. These are indicated as such on the OASIS. All OASIS items are intended to be completed through routine patient assessment approaches and collection of patient subjective and objective data. The items should not be used in the form of a patient interview for collecting data.

A number of software developers currently have software available or are developing software that incorporates the OASIS into their electronic clinical record systems.<sup>1</sup> In addition, stand-

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<sup>1</sup> The OASIS data items have been copyrighted by the Center for Health Policy Research (now termed the Center for Health Services and Policy Research) and are in the public domain. They cannot be further copyrighted for exclusive use by a particular agent or organization.

alone OASIS-specific software, not part of a more comprehensive electronic clinical record system, has been developed for agencies that do not have or are not presently interested in a more comprehensive electronic clinical record system. This stand-alone software enables an agency to computerize or enter OASIS data that have been recorded by clinicians using forms that integrate the OASIS items into the agency's assessment instrument. HAVEN, which is distributed by HCFA at no charge, is an example of this type of software product. Regardless of whether an agency uses a comprehensive electronic clinical record system (possibly with laptops) or stand-alone software to specifically computerize OASIS items, it is important that the exact wording of OASIS items be directly incorporated into the clinical record. Agencies should be certain that their software (1) can be efficiently updated with occasional changes that might occur in OASIS, and (2) provides the capability to extract OASIS items for purposes of transmission to HCFA for outcome comparisons and benchmarking, as well as other agency internal applications that will naturally be of interest once OASIS data are computerized.

Care providers should not have the option to carry the same OASIS data from start of care to follow up in describing or assessing patient health status (this often results in inaccurate follow-up data because providers are tempted to minimize their time by carrying forward the data from the initial time point instead of properly reassessing and recording the information at follow up). This carry-forward approach should not be used in either paper or electronic documentation approaches. That is, assessment forms should not be designed with OASIS data from a prior time period on the same page as data for the current time period, and electronic clinical record software should not be designed so that OASIS data from a prior time period can simply be inserted into the current time period.

Completeness and accuracy of OASIS data are imperative. Not only are these attributes mandatory under HCFA requirements and surveillance policies, but most importantly, complete and accurate OASIS data are essential for individual home health agencies. With precise and comprehensive data, agencies will be able to systematically track case mix changes over time, compare agency-level case mix with a national reference sample, and most importantly, monitor patient outcomes from year to year and relative to national reference outcomes.

This means that agency CEOs, administrators, clinical managers, clinical staff, and fiscal staff should be aware of OASIS' purposes and, most critically, take all possible steps to ensure the accuracy and completeness of OASIS for every patient on whom such data are collected. If this is done, then the agency can derive full benefit from the multiplicity of uses of OASIS.

We wish to repeat that the OASIS was not developed as a comprehensive assessment instrument. It was developed primarily for purposes of measuring outcomes for adult home care patients. Agencies will find it necessary to supplement the OASIS in order to comprehensively assess health status and care needs of patients (for example, the OASIS does not include vital signs nor was it developed with pediatric patients in mind).

It is also important to note that the purpose of measuring patient outcomes through the OASIS is to assist home care agencies with quality improvement activities. In 1995, we authored a book published by the National Association for Home Care, *Outcome-Based Quality Improvement, A Manual for Home Care Agencies on How to Use Outcomes*.<sup>2</sup> This publication provides guidance to agencies on measuring and reporting outcomes and on using them to improve quality.

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<sup>2</sup> For additional information on *Outcome-Based Quality Improvement*, call or write the National Association for Home Care, 228 Seventh St., SE, Washington, DC 20003, (202) 547-7424, fax: (202) 547-3540.



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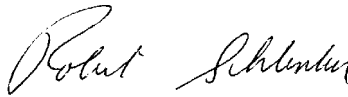


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Peter W. Shaughnessy  
Director



Robert E. Schlenker  
Associate Director



Kathryn S. Crisler  
Assistant Director

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<sup>1</sup> Sample acknowledgement: "The Outcome and ASsessment Information Set (OASIS) is the intellectual property of the Center for Health Services Research, Denver, Colorado. It is used with permission."



## **Outcome and Assessment Information Set OASIS-B1 (12/2002)**

This section includes all items on the OASIS-B1 (12/2002). This contains the full text of all OASIS items. It is included primarily for reference purposes. Home care agencies (that wish to begin integration of OASIS into their comprehensive assessment forms) and/or software developers should use the OASIS items specific to particular types of assessments.

This file is available for viewing, downloading, or printing from CMS' Web site at

<a href="http://www.cms.hhs.gov/oasis/oasisdat.asp">http://www.cms.hhs.gov/oasis/oasisdat.asp</a>
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## Outcome and Assessment Information Set (OASIS-B1)

### Items to be Used at Specific Time Points

<b>Start of Care</b> -----	Home Health Patient Tracking Sheet, M0080-M0825
Start of care—further visits planned	
<b>Resumption of Care</b> -----	M0080-M0825
Resumption of care (after inpatient stay)	
<b>Follow-Up</b> -----	M0080-M0100, M0175, M0230-M0250, M0390, M0420, M0440, M0450, M0460, M0476, M0488, M0490, M0530-M0550, M0610, M0650-M0700, M0825
Recertification (follow-up) assessment	
Other follow-up assessment	
<b>Transfer to an Inpatient Facility</b> -----	M0080-M0100, M0830-M0855, M0890-M0906
Transferred to an inpatient facility—patient not discharged from an agency	
Transferred to an inpatient facility—patient discharged from agency	
<b>Discharge from Agency — Not to an Inpatient Facility</b>	
Death at home -----	M0080-M0100, M0906
Discharge from agency -----	M0080-M0100, M0200-M0220, M0250, M0280-M0380, M0410-M0820, M0830-M0880, M0903-M0906

**Note:** For items M0640-M0800, please note special instructions at the beginning of the section.

### CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN   ☐ 2-PT   ☐ 3-SLP/ST   ☐ 4-OT

(M0090) Date Assessment Completed:

\_\_\_/\_\_\_/\_\_\_  
month   day   year

(M0100) This Assessment is Currently Being Completed for the Following Reason:

#### Start/Resumption of Care

- ☐ 1 – Start of care—further visits planned  
☐ 3 – Resumption of care (after inpatient stay)

#### Follow-Up

- ☐ 4 – Recertification (follow-up) reassessment [ Go to M0175 ]  
☐ 5 – Other follow-up [ Go to M0175 ]

#### Transfer to an Inpatient Facility

- ☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [ Go to M0830 ]  
☐ 7 – Transferred to an inpatient facility—patient discharged from agency [ Go to M0830 ]

#### Discharge from Agency — Not to an Inpatient Facility

- ☐ 8 – Death at home [ Go to M0906 ]  
☐ 9 – Discharge from agency [ Go to M0200 ]

## DEMOGRAPHICS AND PATIENT HISTORY

(M0175) From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days?  
(Mark all that apply.)

- ☐ 1 - Hospital  
☐ 2 - Rehabilitation facility  
☐ 3 - Skilled nursing facility  
☐ 4 - Other nursing home  
☐ 5 - Other (specify) \_\_\_\_\_  
☐ NA - Patient was not discharged from an inpatient facility [ If NA at SOC/ROC, go to M0200; If NA at Follow-Up, go to M0230 ]

(M0180) **Inpatient Discharge Date** (most recent):

\_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

☐ UK - Unknown

(M0190) **Inpatient Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) for only those conditions treated during an inpatient facility stay within the last 14 days (no surgical or V-codes):

<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM</u>
a. _____	(____.____)
b. _____	(____.____)

### Effective 10/1/2003

List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no surgical, E-codes, or V-codes):

<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM</u>
a. _____	(____.____)
b. _____	(____.____)

(M0200) **Medical or Treatment Regimen Change Within Past 14 Days:** Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?

- ☐ 0 - No [ If No, go to M0220 ]  
☐ 1 - Yes

(M0210) List the patient's **Medical Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) for those conditions requiring changed medical or treatment regimen (no surgical or V-codes):

<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-9-CM</u>
a. _____	(____.____)
b. _____	(____.____)
c. _____	(____.____)
d. _____	(____.____)

### Effective 10/1/2003

List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-9-CM</u>
a. _____	(____.____)
b. _____	(____.____)
c. _____	(____.____)
d. _____	(____.____)

**(M0220) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:** If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

- ☐ 1 - Urinary incontinence
- ☐ 2 - Indwelling/suprapubic catheter
- ☐ 3 - Intractable pain
- ☐ 4 - Impaired decision-making
- ☐ 5 - Disruptive or socially inappropriate behavior
- ☐ 6 - Memory loss to the extent that supervision required
- ☐ 7 - None of the above
- ☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- ☐ UK - Unknown

**(M0230/M0240) Diagnoses and Severity Index:** List each medical diagnosis or problem for which the patient is receiving home care and ICD-9-CM code category (three digits required; five digits optional – no surgical or V-codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

**Effective 10/1/2003**

List each diagnosis and ICD-9-CM code at the level of highest specificity (no surgical codes) for which the patient is receiving home care. Rate each condition using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) E-codes (for M0240 only) or V-codes (for M0230 or M0240) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then M0245 Payment Diagnosis should be completed. Case mix diagnosis is a primary or first secondary diagnosis that determines the Medicare PPS case mix group.

Severity Rating

- 0 - Asymptomatic, no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
- 3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring
- 4 - Symptoms poorly controlled, history of rehospitalizations

<u>(M0230) Primary Diagnosis</u>	<u>ICD-9-CM</u>	<u>Severity Rating</u>
a. _____	( ____ . ____ )	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
 <u>(M0240) Other Diagnoses</u>		
b. _____	( <input type="checkbox"/> ____ . ____ )	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
c. _____	( <input type="checkbox"/> ____ . ____ )	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
d. _____	( <input type="checkbox"/> ____ . ____ )	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
e. _____	( <input type="checkbox"/> ____ . ____ )	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
f. _____	( <input type="checkbox"/> ____ . ____ )	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

**Effective 10/1/2003**

**(M0245) Payment Diagnosis (optional):** If a V-code was reported in M0230 in place of a case mix diagnosis, list the primary diagnosis and ICD-9-CM code, determined in accordance with OASIS requirements in effect before October 1, 2003--no V-codes, E-codes, or surgical codes allowed. ICD-9-CM sequencing requirements must be followed. Complete both lines (a) and (b) if the case mix diagnosis is a manifestation code or in other situations where multiple coding is indicated for the primary diagnosis; otherwise, complete line (a) only.

<u>(M0245) Primary Diagnosis</u>	<u>ICD-9-CM</u>
a. _____	( ____ . ____ )
<u>(M0245) First Secondary Diagnosis</u>	<u>ICD-9-CM</u>
b. _____	( ____ . ____ )

**(M0250) Therapies** the patient receives at home: **(Mark all that apply.)**

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

**(M0260) Overall Prognosis:** BEST description of patient's overall prognosis for recovery from this episode of illness.

- ☐ 0 - Poor: little or no recovery is expected and/or further decline is imminent
- ☐ 1 - Good/Fair: partial to full recovery is expected
- ☐ UK - Unknown

**(M0270) Rehabilitative Prognosis:** BEST description of patient's prognosis for functional status.

- ☐ 0 - Guarded: minimal improvement in functional status is expected; decline is possible
- ☐ 1 - Good: marked improvement in functional status is expected
- ☐ UK - Unknown

**(M0280) Life Expectancy:** (Physician documentation is not required.)

- ☐ 0 - Life expectancy is greater than 6 months
- ☐ 1 - Life expectancy is 6 months or fewer

**(M0290) High Risk Factors** characterizing this patient: **(Mark all that apply.)**

- ☐ 1 - Heavy smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

## **LIVING ARRANGEMENTS**

**(M0300) Current Residence:**

- ☐ 1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
- ☐ 2 - Family member's residence
- ☐ 3 - Boarding home or rented room
- ☐ 4 - Board and care or assisted living facility
- ☐ 5 - Other (specify) \_\_\_\_\_

**(M0340) Patient Lives With: (Mark all that apply.)**

- ☐ 1 - Lives alone
- ☐ 2 - With spouse or significant other
- ☐ 3 - With other family member
- ☐ 4 - With a friend
- ☐ 5 - With paid help (other than home care agency staff)
- ☐ 6 - With other than above

**SUPPORTIVE ASSISTANCE**

**(M0350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.)**

- ☐ 1 - Relatives, friends, or neighbors living outside the home
- ☐ 2 - Person residing in the home (EXCLUDING paid help)
- ☐ 3 - Paid help
- ☐ 4 - None of the above [ If None of the above, go to M0390 ]
- ☐ UK - Unknown [ If Unknown, go to M0390 ]

**(M0360) Primary Caregiver** taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):

- ☐ 0 - No one person [ If No one person, go to M0390 ]
- ☐ 1 - Spouse or significant other
- ☐ 2 - Daughter or son
- ☐ 3 - Other family member
- ☐ 4 - Friend or neighbor or community or church member
- ☐ 5 - Paid help
- ☐ UK - Unknown [ If Unknown, go to M0390 ]

**(M0370) How Often** does the patient receive assistance from the primary caregiver?

- ☐ 1 - Several times during day and night
- ☐ 2 - Several times during day
- ☐ 3 - Once daily
- ☐ 4 - Three or more times per week
- ☐ 5 - One to two times per week
- ☐ 6 - Less often than weekly
- ☐ UK - Unknown

**(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.)**

- ☐ 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
- ☐ 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
- ☐ 3 - Environmental support (housing, home maintenance)
- ☐ 4 - Psychosocial support (socialization, companionship, recreation)
- ☐ 5 - Advocates or facilitates patient's participation in appropriate medical care
- ☐ 6 - Financial agent, power of attorney, or conservator of finance
- ☐ 7 - Health care agent, conservator of person, or medical power of attorney
- ☐ UK - Unknown

**SENSORY STATUS**

**(M0390) Vision** with corrective lenses if the patient usually wears them:

- ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.